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Editorial

The Problem With Maslow's Hammer

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Somewhere between 15% and 65% of elders living in nursing homes and residential care facilities have significant depression and anxiety[1] and these symptoms have only intensified during the COVID-19 pandemic.[2] Depression and anxiety are major contributors to decreased quality of life for older adults and are associated with poor health outcomes, social isolation, functional decline including premature death and increasing the burden on nursing home staff and caregivers.[3,4] Mood disorders in late life are also often unrecognized clinically and more likely to have a complicated clinical course and incomplete recovery and.[5]

Despite this urgent need in our communities, we continue to struggle with the appropriate interventions to manage these symptoms.

For most residents in long term care facilities (LTCF), formal psychotherapy with a licensed therapist is not available and the primary treatment is pharmacotherapy. The percent of nursing home residents on antidepressants in U.S. nursing homes more than doubled between 1996 to 2006 from 21.9% to 47.5%.[6] This would seem to show that we are focusing more on treating depression, but often antidepressants are not prescribed following evidenced based guidelines.[7,8] Patients are prescribed suboptimal doses of antidepressants or antidepressants are targeted for the off-label treatment of insomnia, agitation (e.g., trazodone or mirtazapine) or chronic pain (e.g., amitriptyline).

There has also been an increase in the off-label use of atypical antipsychotics in the U.S. perhaps in response to the Centers for Medicare and Medicaid Services (CMS) regulations regarding the use of benzodiazepines in nursing homes. These regulations have added scrutiny on the indiscriminate and long-term use of minor tranquilizers. Atypical antipsychotics are being used increasingly for a number of off-label indications including insomnia, agitation and dementia despite serious adverse side effects including hip fractures, orthostatic hypotension, and pneumonia and, in dementia patients, evidence for a decline in cognition and functional abilities as well as premature mortality.[9]

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Then there is the issue of how many medications our elderly residents are taking. Polypharmacy in long term care facilities was reviewed in 35 studies and the investigators found that 91% of LTCF residents were taking five or more medications and 65% of residents were taking 10 or more medications.[10] Nursing home residents with advanced dementia were on a mean of 5.9 ± 3.0 daily medications (53.6% on antidepressants and 27.9% on antipsychotics) and even modest reductions only occur during the last week of life.

Which brings us to Maslow's hammer: "I suppose it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail."[11] Abraham Maslow was a prominent psychologist in the twentieth century and this axiom was intended to encourage individuals to become more resilient by expanding their coping strategies. But this axiom could equally apply to all of us who care for the frail elderly in residential care homes. We often rely on medications as our primary therapeutic intervention and the data would show that medications may be overprescribed or not prescribed according to the evidence-based literature.

Do we really believe there is "a pill for every ill"[12]?

Clearly a subgroup of long-term care residents suffer from moderate to severe depression or primary anxiety disorders and may need aggressive pharmacotherapy and in some cases inpatient hospitalization and/or electroconvulsive therapy. There should be a system in place where these patients are identified early and receive appropriate treatment.

There is a larger group of residents who would readily ascribe to various degrees of loneliness, loss of purpose, social isolation, unresolved grief, anxiety about finances and fear of dying. Many of our LCTF residents move due to necessity, and not by choice. These elders may meet criteria for mild to moderate depression but would probably not respond to an antidepressant alone.

In this issue of the journal, Almeida et al.[13] explore an alternative model for treating elders in long term care settings. In this model they prescribe another tool in the long-term care setting- caregivers providing Behavioral Activation (BA). The model Almeida et al. describe empowers caregivers to recognize and treat symptoms of depression and anxiety. BA is manualized and requires minimal psychological sophistication to implement in this setting. BA can also be applied in populations with mild to moderate dementia which was present in 55%–65% of the target population in this study. Residents with physical limitations were also included in the study making BA an ideal therapeutic intervention in the LTC environment.

What is missing in this study is a measure of staff satisfaction. Although the primary endpoints of a decrease in depression and anxiety were not met, the training for caregivers with a focus on individualized care for the residents provides immeasurable benefits. Providing training to caregivers gives them skills to recognize depression and empowers them to identify appropriate residents for BA vs. those who needed a higher level of care. This is a level of care that personalizes treatment dependent of the resident's needs.

There are several impediments to providing nonpharmacological treatment for residents in long term care facilities in the U.S. due to the present reimbursement structure for medical care. Medicare and Medicaid provide fees for skilled services (i.e., provider must have professional medical training and be licensed) and usually does not reimburse for other services such as custodial care (bathing and dressing) which may be where reimbursement for BA with LTC caregivers would fall. There is progress. In 2018, the Centers for Medicare and Medicaid (CMS) allowed for healthcare benefits in Medicare Advantage plans that would improve functional recovery and decrease the need for services. This type of program could be reimbursed under that coverage but that is far from certain. We should all advocate for this coverage.

We need to continue to investigate and refine nonpharmacological interventions to treat depression and anxiety symptoms in LTCF's to improve the lives of our patients and provide needed treatment options. We can only work with the tools we are given, and we need more tools.

AUTHOR CONTRIBUTIONS

William M. McDonald, M.D. is the sole contributor of this editorial.

DATA STATEMENT

The data has not been previously presented orally or by poster at scientific meetings.

DISCLOSURES

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